

5522

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Carroll Middle C. Last Algard				4. DATE OF DEATH Month May Day 7 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 16 1883		9. AGE (In years and birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. Trackman		10b. KIND OF BUSINESS OR INDUSTRY Ret 9 years		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Valentine B. Algard				14. MOTHER'S MAIDEN NAME Mary Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Bdna Mae Algard Charlestown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocarditis 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Osteomyelitis Right foot						INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 18, 1958 , to May 6, 1959 , that I last saw the deceased alive on May 6, 1959 , and that death occurred at 7:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Clarence I. Benson M.D.				ADDRESS (Street, city or town, state) Port Deposit Md. DATE SIGNED 5/7/59			
PHYSICIAN'S NAME (Type) CLARENCE I. BENSON							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 10, 1959		22c. NAME OF CEMETERY OR CREMATORY Charlestown		22d. LOCATION (City, town, or county) (State) Charlestown, Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant ADDRESS North East, Maryland				24a. REC'D BY REGISTRAR DATE MAY 12 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Huns	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5523

CERTIFICATE OF DEATH

05496

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2 1/2 mi. W of Rising Sun</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>CLARENCE B. BAUGHMAN</u>		4. DATE OF DEATH <u>May 12 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 2, 1900</u>
9. AGE (In years, last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Builder</u>	
11. BIRTHPLACE (State or foreign country) <u>State of Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Baughman</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Baughman, Colore Md</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01-7943</u>	
17. INFORMANT <u> </u> Address <u> </u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u> </u> 19 <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/8</u> , 19 <u>58</u> to <u>5/12</u> , 19 <u>59</u> that I last saw the deceased alive on <u>5/11</u> , 19 <u>59</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.		ADDRESS (Street, city or town, state) <u>Rising Sun, Maryland</u> DATE SIGNED <u>5/13/59</u>	
PHYSICIAN'S NAME (Type) <u> </u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>5/14/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham</u>		22d. LOCATION (City, town, or county) (State) <u>Colore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M Reed, Rising Sun, Md</u> ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>MAY 14 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05497

5524

CERTIFICATE OF DEATH

Reg. Dist. No. 96

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatoblastoma with metastases to the lymph nodes around the celiac axis about the pancreas and the hilum of the liver</u> DUE TO (b) <u>and the hilum of the liver</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 13</u> , 19 <u>59</u> , to <u>May 24</u> , 19 <u>59</u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>J. L. GAREY</u>		M.D. <u>V.A. Hospital, Perry Point, Md. 5-25-59</u>	
PHYSICIAN'S NAME (Type) <u>J. L. GAREY</u>		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>MAY 28 '59</u>		<u>Arthur S. Hays</u>	

CERTIFICATE OF DEATH

State of New York

County of

Town of

City of

Ward of

Block of

Dec. 1, 1900

Age

Sex

Mar.

Prof.

Rel.

Color

Temp.

Pulse

Respiration

By

Physician

By

Physician

By

Physician

Signature

Signature

Signature

Signature

Signature

Dec. 1, 1900

and the date of the death

Dec. 1, 1900

Dec. 1, 1900

Dec. 1, 1900

Dec. 1, 1900

Dec. 1, 1900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05498

5503

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elk ton</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2/ Elkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Linda</u> Middle <u>Susan</u> Last <u>Billings</u>			4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>19 59</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11, 1954</u>		9. AGE (In years last birthday) <u>4</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Chester L. Billings, Sr.</u>			14. MOTHER'S MAIDEN NAME <u>Gertrude G. Seymour</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) -----		17. INFORMANT Address <u>Mrs. Gertrude Billings, Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Glomerulonephritis</u> <u>592x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO ----- (c) DUE TO -----					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from, 19, to, <u>20 May, 19 59</u> , that I last saw the deceased alive on <u>19 May, 19 59</u> , and that death occurred at <u>2 30</u> P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Clifton R. Brooks</u>		M.D. <u>269 E. Main Street</u>		DATE SIGNED <u>5/20/59</u>	
PHYSICIAN'S NAME (Type) <u>Clifton R. Brooks</u>		<u>Newark, Del</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 22/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Cherry Hill, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 27 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clifton R. Brooks</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5525

CERTIFICATE OF DEATH

Reg. Dist. No. **05499**

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nottingham, R.D. 1 c. LENGTH OF STAY IN 1b 10 yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Graybeal Nursing Home				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JESSE Middle T Last BLACKSON			4. DATE OF DEATH Month 5-8 Day 19 Year 59				
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH June 1876		9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min. 82			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY All kinds work		11. BIRTHPLACE (State or foreign country) Perryville, Md.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME AARON BLACKSON			14. MOTHER'S MAIDEN NAME MARY MAHAN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-18-1975		INFORMANT Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from May 1st , 19 59 , to 5-8-59 , 19____, that I last saw the deceased alive on 5-8-59 , 19____, and that death occurred at 3 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rising Sun, Md. 5-9-59							
ACTUAL SIGNATURE R.C. Dodson		DATE SIGNED 5-9-59					
PHYSICIAN'S NAME (Type) R.C. Dodson							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-11-59		22c. NAME OF CEMETERY OR CREMATORY Principios			
22d. LOCATION (City, town, or county) Principios, Cecil Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson + Son, Perryville, Md.		24a. REC'D BY REGISTRAR MAY 12 '59		24b. REGISTRAR'S SIGNATURE Claring & Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05493

2252

1

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

5526 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Wyoming b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecil		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 87X-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Unknown			
3. NAME OF DECEASED (Type or print) First PAUL Middle (NMI) Last BOGATAJ		4. DATE OF DEATH Month May Day 7 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-24-94
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR: Months 65 Days 65 Hours 65 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal	
11. BIRTHPLACE (State or foreign country) Jugoslavia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia bilateral unresolved 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized severe INTERVAL BETWEEN ONSET AND DEATH 4-5 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. VA 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 28, 1943 , to May 7, 1959 , and that death occurred at 8:40a M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 5-8-59			
ACTUAL SIGNATURE J. L. GAREY		M.D. V.A. Hospital, Perry Point, Md.	
PHYSICIAN'S NAME (Type) J. L. GAREY		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) 5/12/59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		ADDRESS	
24a. REC'D BY REGISTRAR MAY 18 '59		24b. REGISTRAR'S SIGNATURE Arthur & Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05501

Reg. Dist. No.

5527

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Del. b. COUNTY Newcastle			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D.		c. LENGTH OF STAY IN 1b all life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark, & Christiana			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Franklin Middle Stanley Last Bryan				4. DATE OF DEATH Month 5 Day 13 Year 19 59			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-23-1922		9. AGE (In years last birthday) 37 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Private		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George S. Bryan				14. MOTHER'S MAIDEN NAME Helen Bullock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W.2 217-18-3759		17. INFORMANT Address Mrs. Helen Bullock, Townsend, Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pistal bullet in center of Forehead DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self after shooting wife					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Elkton, R.D. Cecil Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 17, 1959		22c. NAME OF CEMETERY OR CREMATORY North East Cemetery		22d. LOCATION (City, town, or county) (State) North East Cecil Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant				ADDRESS North East Md		24a. REC'D BY REGISTRAR MAY 20 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

5528

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05502

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 126 Market Place	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harvy Wharf - North East				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Berkley Butler				4. DATE OF DEATH Month Day Year May 24 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 16, 19 30	
9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Gen. Electric Co.		11. BIRTHPLACE (State or foreign country) BALTO Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ALBERT C. BUTLER				14. MOTHER'S MAIDEN NAME MARY C. BUTLER Cecelia Butler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 217-24-3891		17. INFORMANT 110 S. Culver St. Address MRS. MARY Cecelia HINKEL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to drowning 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found floating in water					
20c. TIME OF INJURY Month, Day, Year Hour a. m. May 20 19 59 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River		20f. (City or town) (County) (State) Rising Sun Cecil Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles S. Petty				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles S. Petty				DATE SIGNED 5/24/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 26, 1959		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cem.		22d. LOCATION (City, town, or county) (State) Balto. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. J. J. J.				ADDRESS 3512 Frederick Ave. (29)		24a. REC'D BY REGISTRAR DATE MAY 26 '59	
				24b. REGISTRAR'S SIGNATURE Charles J. J. J.			

Chloroform

1

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5529

CERTIFICATE OF DEATH

Reg. Dist. No.

05503

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cecilton		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
c. LENGTH OF STAY IN 1b		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cecilton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First CHARLES Middle HENRY Last BYERLY Jr.		4. DATE OF DEATH Month May Day 10 Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March, 27, 1889
9. AGE (In years at birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist		10b. KIND OF BUSINESS OR INDUSTRY Florist	
11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Henry Byerly, I		14. MOTHER'S MAIDEN NAME Fannie Gest	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 197-12-0690	
17. INFORMANT Mrs. Anna Byerly,		Address Cecilton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-intestinal hemorrhage 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic urinary bladder carcinoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) senility			INTERVAL BETWEEN ONSET AND DEATH 2 days 7 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1954 , 19____, to May 10 , 19 59 , that I last saw the deceased alive on May 10 , 19 59 , and that death occurred at 8:00a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cecilton, Md. DATE SIGNED 11 May 59			
ACTUAL SIGNATURE Wallace Obenshain M.D. PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May, 12, 1959	22c. NAME OF CEMETERY OR CREMATORY Arlington, Cemetery	22d. LOCATION (City, town, or county) (State) Philadelphia, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows		24a. REC'D BY REGISTRAR DATE MAY 12 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05504

5504

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Delaware b. COUNTY New Castle			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark 46 X 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 5 Phillips Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harry F. Cavender				4. DATE OF DEATH Month Day Year May 15, 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 17, 1881		9. AGE (In years last birthday) yrs. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Cavender				14. MOTHER'S MAIDEN NAME Sadie Moore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT 5 Phillips Ave. Mrs. Florence M. Cavender Newark, Delaware			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 584X Rupture of gall bladder DUE TO (b) Cholelithiasis + Cholecystitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity + Gen Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 18 hours Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-14-1959 to 5-15-1959, that I last saw the deceased alive on 5-14-1959, and that death occurred at 6:55 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Williford Eppes M.D. 325 E. Main St 5-15-59 PHYSICIAN'S NAME (Type) Williford Eppes Newark Del							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 18, 1959		22c. NAME OF CEMETERY OR CREMATORY Bethel Cem.		22d. LOCATION (City, town, or county) (State) Bethel, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE K.T. Jones				ADDRESS Newark Del		24a. REC'D BY REGISTRAR DATE MAY 19 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

CERTIFICATE OF DEATH

Obesity & Gen Arteriosclerosis
 Cholelithiasis & Cholecystitis
 Rupture of gall bladder
 18 years

Willard Ebbes
 352 E. Main St
 Newark Del
 2-12-24
 2-14
 2-18-24

5530 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 5 mo. 28 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C. d. STREET ADDRESS ? 47x-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle CLARK Last CLARK		4. DATE OF DEATH Month 5 Day 26 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-17-1900
9. AGE (In years last birthday) 58		10. IF UNDER 1 YEAR Months 5 Days 26 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Gilligen (Dec.)		14. MOTHER'S MAIDEN NAME Elizabeth Clark (Dec.)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL, UNRESOLVED. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA, RECURRENT, SITE OF LARYNGECTOMY, WITH EROSION INTO THE LEFT CAROTID VESSEL (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 4 To 5 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. VA p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-31-34 , 19, to 5-26- , 19 59 and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. P. Lacerva M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) S. P. LACERVA, M.D.		VA HOSPITAL, PERRY POINT, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 6/1/59	
22c. NAME OF CEMETERY OR CREMATORY Balto. Md.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harold de la Cruz, Md.		24a. REC'D BY REGISTRAR JUN 3 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. House	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5138

Perry, John

John Perry

John

1910-1911

John

John

John Perry

John Perry

John Perry

John Perry

John Perry

John Perry

John Perry

1910-1911

1910-1911

John Perry

John Perry

John Perry

1910-1911

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5505

CERTIFICATE OF DEATH

05506

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Haven Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East	
3. NAME OF DECEASED (Type or print) First Dr. Clarence Middle B. Last Collings Jr.		4. DATE OF DEATH Month May Day 29 Year 19 59	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-4-1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		9. AGE (In years last birthday) 72 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) TEXAS	
13. FATHER'S NAME Clarence B. Collings Sr.		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		14. MOTHER'S MAIDEN NAME Louise N. Miller	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Louise C. Fitch Jacksonville Florida	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from October 6, 1956 , to May 29, 1959 , that I last saw the deceased alive on May 28, 1959 , and that death occurred at 8:06a M. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Ralph Andrews, Jr., M.D.		ADDRESS (Street, city or town, state) 233 E. Main St. Elkton, Maryland	
DATE SIGNED May 29, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 1, 1959	
22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		24a. REC'D BY REGISTRAR DATE JUN 3 '59	
ADDRESS North East, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05508

Reg. Dist. No.

5506

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital			d. STREET ADDRESS 148 W. Main St. Union Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JO Middle ANN Last DUNLAP			4. DATE OF DEATH May 23, 1959		
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 16, 1959	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR Months Day Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Carroll M. Dunlap			14. MOTHER'S MAIDEN NAME Katherine Simpers		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Father Address Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature 756.2 DUE TO Possible Poisoning & Chorea Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 7 days 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 May, 1959, to 23 May, 1959, that I last saw the deceased alive on 23 May, 1959, and that death occurred at 7:25 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE George J. Kreis		M.D. Elkton, Md.		DATE SIGNED 5/25/59	
PHYSICIAN'S NAME (Type) George J. Kreis					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/25/1959		22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Park	
				22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		ADDRESS Donald M. De		24a. REC'D BY REGISTRAR DATE JUN 1 '59	
		Elkton, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2065233XVI

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1900</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. COLOR <i>White</i>		9. RELIGION <i>Methodist</i>		10. EDUCATION <i>High School</i>		11. PRESENT RESIDENCE <i>123 Main St. Baltimore, Md.</i>		12. DATE OF DEATH <i>Jan 20 1945</i>	
13. CAUSE OF DEATH <i>Heart Disease</i>		14. MANNER OF DEATH <i>Natural</i>		15. PLACE OF DEATH <i>Home</i>		16. TIME OF DEATH <i>10:30 AM</i>		17. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		18. SIGNATURE OF REGISTRAR <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05509

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN lb all life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Aiken Ave		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Aiken Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle C Last Edwards		4. DATE OF DEATH Month 5 Day 7 Year 19 59	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-20-1899
9. AGE (in years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Perryville Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Ward		14. MOTHER'S MAIDEN NAME Mary Chamberlain	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-30-5674	
17. INFORMANT Nancy Edwards, Perryville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		DATE SIGNED 5-8-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-9-1959	
22c. NAME OF CEMETERY OR CREMATORY Principio Cemetery		22d. LOCATION (City, town, or county) (State) Principio Furnace, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee P. Cathers & Sons		ADDRESS Perryville, Md.	
24a. REC'D BY REGISTRAR DATE MAY 11 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5507

CERTIFICATE OF DEATH

Reg. Dist. No.

05510

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION HOSPITAL		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Thomas Leroy Foard		4. DATE OF DEATH May 11 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/21/1888
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store-keeper		10b. KIND OF BUSINESS OR INDUSTRY Sales	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas J. Foard		14. MOTHER'S MAIDEN NAME Eva Cummings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Myrtle V. Foard		Address Ches. City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma of Prostate DUE TO (c) 3 yrs.		INTERVAL BETWEEN ONSET AND DEATH 3 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sensibility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 9, 19 59 to May 11, 19 59 , that I lost s/he the deceased on May 11, 19 59 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wallace Obenshain M.D.		ADDRESS (Street, city or town, state) Cecilton, Md. DATE SIGNED 12 May 59	
PHYSICIAN'S NAME (Type) Wallace Obenshain			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/14/1959	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE MAY 14 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

5532

CERTIFICATE OF DEATH

Reg. Dist. No.

05512

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Cecil</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>rural - Calvert md</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Bertie</i> Middle <i>D</i> Last <i>Lualtney</i>				4. DATE OF DEATH Month <i>May</i> Day <i>1</i> Year <i>1959</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 24 1882</i>	9. AGE (In years last birthday) <i>76</i> yrs.	IF UNDER 1 YEAR Months <i>76</i> Days <i>76</i> Hours <i>76</i> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Rugby, Nassau Co Va</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				13. FATHER'S NAME <i>Joseph Reedy</i>			
14. MOTHER'S MAIDEN NAME <i>Jane Shelton</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <i>Viola Lualtney, Nottingham P. I. Pa</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arthritis deformans</i> <i>723.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <i>15 years</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <i>9</i> p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>May 1</i> 19 <i>50</i> to <i>May 1</i> 19 <i>59</i> , that I last saw the deceased alive on <i>May 1</i> 19 <i>59</i> , and that death occurred at <i>9 A M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>B. Robinson</i> M.D. <i>May 2 1959</i>							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>May 4 1959</i>		<i>Oxford Cem.</i>		<i>Oxford - Chester Co Pa</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph M Reed, Rising Sun, Md</i>				24a. REC'D BY REGISTRAR DATE <i>MAY 5 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kraus</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5508 CERTIFICATE OF DEATH

05511

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Earleville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HOWARD Middle GREEN Last GREEN		4. DATE OF DEATH Month May Day 13 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May, 13, 1900
9. AGE (In years last birthday) yrs. 79		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Green		14. MOTHER'S MAIDEN NAME Mollie Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-26-6403A	
17. INFORMANT Mrs. Mary E. Husfelt,		Address Earleville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 15 hours years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 13 May , 19 59 to 13 May , 19 59 , that I last saw the deceased alive on 13 May , 19 59 , and that death occurred at 4:30p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Wallace Obenshain M.D. Cecilton, Md. 16 May 59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 17, 1959	22c. NAME OF CEMETERY OR CREMATORY Sudlersville Cemetery	22d. LOCATION (City, town, or county) (State) Sudlersville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edward G. Holloway, Millington, Md.		24a. REC'D BY REGISTRAR DATE MAY 20 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

סנדק 1.5

13. 10. 1991

0021-212X/96/0000-0000\$05.00/0

▲

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

5509

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05513

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE N. Y. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York 69X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Union Hospital		d. STREET ADDRESS Sullivan St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KITTY HOLLAND		4. DATE OF DEATH Month 5 Day 17 Year 59	
5. SEX F.	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1900
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) London, England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harris Marcus		14. MOTHER'S MAIDEN NAME Fannie Marcus	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Evelyn Greenburg		Address Kerhounkson, N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/17/ 1959	
22c. NAME OF CEMETERY OR CREMATORY Wellwood Cemetery		22d. LOCATION (City, town, or county) (State) Pinelawn, N. Y.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR DATE MAY 21 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. House	

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5209

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
OCCUPATION		EDUCATION		MARRIAGE		SINGLE		MARRIED	
CAUSE OF DEATH		MANNER OF DEATH		TOXICOLOGY		ALCOHOL		DRUGS	
HISTORICAL		PHYSICAL		LABORATORY		X-RAY		PATHOLOGICAL	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		CITY	
SIGNATURE OF WITNESS		DATE		TIME		PLACE		CITY	
SIGNATURE OF JURY		DATE		TIME		PLACE		CITY	
SIGNATURE OF JUDGE		DATE		TIME		PLACE		CITY	
SIGNATURE OF CLERK		DATE		TIME		PLACE		CITY	
SIGNATURE OF SHERIFF		DATE		TIME		PLACE		CITY	
SIGNATURE OF CORONER		DATE		TIME		PLACE		CITY	
SIGNATURE OF DISTRICT ATTORNEY		DATE		TIME		PLACE		CITY	
SIGNATURE OF COUNTY CLERK		DATE		TIME		PLACE		CITY	
SIGNATURE OF TOWNSHIP CLERK		DATE		TIME		PLACE		CITY	
SIGNATURE OF VILLAGE CLERK		DATE		TIME		PLACE		CITY	
SIGNATURE OF POST OFFICE CLERK		DATE		TIME		PLACE		CITY	
SIGNATURE OF SCHOOL CLERK		DATE		TIME		PLACE		CITY	
SIGNATURE OF CHURCH CLERK		DATE		TIME		PLACE		CITY	
SIGNATURE OF MINISTRY CLERK		DATE		TIME		PLACE		CITY	
SIGNATURE OF OTHER CLERK		DATE		TIME		PLACE		CITY	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5510 CERTIFICATE OF DEATH

Reg. Dist. No.

05514

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Earleville			
d. NAME OF HOSPITAL (If not in hospital, give street address) Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY First E. Middle HUSFELT Last				4. DATE OF DEATH Month May Day 23 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June, 13, 1882		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Davis				14. MOTHER'S MAIDEN NAME Laura Biggs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Frank Husfelt,		Address Earleville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-vascular Disease DUE TO (c) years						INTERVAL BETWEEN ONSET AND DEATH 4 hours.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute mesenteric Thrombosis - 12 hours before death						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 54 , to May 23 , 19 59 , that I last saw the deceased alive on May 23 , 19 59 , and that death occurred at 7:00 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Wallace Obenshain				ADDRESS (Street, city or town, state) Cecilton, Md.		DATE SIGNED 25 May 59	
PHYSICIAN'S NAME (Type) WILLACE OBENSHAIN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May, 26, 1959		22c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery		22d. LOCATION (City, town, or county) (State) Cecilton, Cecil Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Sellows				ADDRESS Wilmington, Md.		24a. REC'D BY REGISTRAR DATE MAY 28 59	
				24b. REGISTRAR'S SIGNATURE W. J. Frank			

5533 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last James G. Jones				4. DATE OF DEATH Month Day Year May 26 1959			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-2-1880		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner		10b. KIND OF BUSINESS OR INDUSTRY Veg. Raising		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Samuel Jones				14. MOTHER'S MAIDEN NAME Berna Priest			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs Ernest Demond North East, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO 15 years (c)						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from May 24 , 19 59 , to 26 May , 19 59 , that I last saw the deceased alive on 24 May , 19 59 , and that death occurred at 8 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) North East, Md DATE SIGNED 27 May '59 ACTUAL SIGNATURE Klaus H. Heubner M.D. Klaus H. Heubner M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 29, 1959	22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Md		
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant ADDRESS North East, Maryland				24a. REC'D BY REGISTRAR DATE JUN 1 '59		24b. REGISTRAR'S SIGNATURE Carlton S. Finner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G242 5-18-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

05516

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> 14X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ELKTON Union Hospital</u>				d. STREET ADDRESS <u>14X-2</u>			
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>E.</u> Last <u>Kelley</u>				4. DATE OF DEATH Month <u>5</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/7/1894</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>U.S. MARYLAND</u>	
13. FATHER'S NAME <u>Edward Jenkins</u>				12. CITIZEN OF WHAT COUNTRY? <u>Yes USA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Virginia Warner</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Profound anemia, cause undetermined; generalized arthritis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>o. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1959</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May 2</u> , 19 <u>59</u> , to <u>May 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 7</u> , 19 <u>59</u> , and that death occurred at <u>6:23 p.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Ralph Andrews, Jr.</u>				ADDRESS (Street, city or town, state) <u>233 E. Main Street</u> DATE SIGNED <u>May 7, 1959</u>			
PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u>				Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Hall</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Alfonso L. San Cloud Hill</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Handwritten: Mary Ann Jones]</p>		<p>2. SEX [Handwritten: Female]</p>		<p>3. AGE [Handwritten: 65 years]</p>	
<p>4. DATE OF DEATH [Handwritten: May 15, 1964]</p>		<p>5. TIME OF DEATH [Handwritten: 10:30 AM]</p>		<p>6. PLACE OF DEATH [Handwritten: Home]</p>	
<p>7. OCCUPATION [Handwritten: None]</p>		<p>8. MARITAL STATUS [Handwritten: Widowed]</p>		<p>9. PLACE OF BIRTH [Handwritten: Baltimore, Maryland]</p>	
<p>10. CAUSE OF DEATH [Handwritten: Myocardial Infarction]</p>		<p>11. MANNER OF DEATH [Handwritten: Natural]</p>		<p>12. SIGNATURE OF PHYSICIAN [Handwritten: J. Edgar Smith, M.D.]</p>	
<p>13. SIGNATURE OF REGISTRAR [Handwritten: J. Edgar Smith, M.D.]</p>		<p>14. SIGNATURE OF WITNESS [Handwritten: J. Edgar Smith, M.D.]</p>		<p>15. SIGNATURE OF WITNESS [Handwritten: J. Edgar Smith, M.D.]</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5512 CERTIFICATE OF DEATH

Reg. Dist. No.

05517

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 317 W. Main Street		d. STREET ADDRESS 317 W. Main Street	
3. NAME OF DECEASED (Type or print) First Katie Middle Marcus Last Marcus		4. DATE OF DEATH Month May Day 28 Year 1959	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY at Home	9. AGE (In years lost birthday) 74 yrs. Months 7 Days 18 Hours 59 Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Bullen		14. MOTHER'S MAIDEN NAME Ida Woodrow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. William H. Marcus		Address Elkside, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis; Carcinoma of coronary			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 25, 1953 to May 25, 1959 , that I last saw the deceased alive on May 25, 1959 , and that death occurred at 7:10 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Milford H. Sprecher M.D.		DATE SIGNED 135 W. Main, Elkside, Md. May 26	
PHYSICIAN'S NAME (Type) Milford H. Sprecher			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/28/1959	22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Park	22d. LOCATION (City, town, or county) (State) Elkton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. H. PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR Elkton, Md.	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

5513 CERTIFICATE OF DEATH

05518

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City			
				d. STREET ADDRESS /			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last I. Day McCauley				4. DATE OF DEATH Month Day Year May 12, 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 16, 1877	
				9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent				10b. KIND OF BUSINESS OR INDUSTRY Insurance			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James T. McCauley				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-03-5519			
				17. INFORMANT Address David R. McCauley, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Colon with metastasis 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — INTERVAL BETWEEN ONSET AND DEATH 4 1/2 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. — 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from Mar 16, 1955, to 12 May, 1959, that I last saw the deceased alive on 12 May, 1959, and that death occurred at 12:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Klaus H. Huebner M.D. North East, Md. 12 May '59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) KLAUS H. HUEBNER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/15/59		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cherry Hill, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks				ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE MAY 20 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kneiss			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05519

5534 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton R.D.3				c. LENGTH OF STAY IN 1b all life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Nora First B. Middle Mendenhall Last				4. DATE OF DEATH Month 5 Day 27 Year 19 59			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH -1-5-1874	9. AGE (In years lost birthday) 85 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph B. Yerkes				14. MOTHER'S MAIDEN NAME Mary Erwin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mrs. James F. Allen, Carrcroft. W.I. Del. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 432.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Atherosclerosis extreme and nephritis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) _____ INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1956 , 19____, to 5-18-59 , 19____, that I last saw the deceased alive on 5-18-59 , 19____, and that death occurred at 6 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R.C. Dodson		ADDRESS (Street, city or town, state) Rising Sun, Md.		DATE SIGNED 5-28-59			
PHYSICIAN'S NAME (Type) R.C. Dodson, M.D.		Rising Sun, Md.					
22a. BURIAL, CREMATION, REMOVAL, SPECIFY Burial		22b. DATE THEREOF 5-31-59		22c. NAME OF CEMETERY OR CREMATORY Rosebank		22d. LOCATION (City, town, or county) (State) Calvert Cecil, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks ADDRESS Elkton, Md.				24a. REC'D BY REGISTRAR Arthur S. Hines		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	
				DATE JUN 4 '59			

03519

CERTIFICATE OF DEATH

1. NAME OF DECEASED KELTON, RICHARD		2. SEX Male		3. AGE 41	
4. DATE OF DEATH April 11, 1941		5. TIME OF DEATH 11:15 A.M.		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. DISEASE OR INJURY Coronary Artery Disease		9. MANNER OF DEATH Natural	
10. SIGNATURE OF PHYSICIAN J. Edgar Smith, M.D.		11. SIGNATURE OF WITNESS John Doe, M.D.		12. SIGNATURE OF DECEASED (If living)	
13. SIGNATURE OF REGISTRAR Mary Jones		14. SIGNATURE OF CLERK John Doe		15. SIGNATURE OF DECEASED (If living)	
16. SIGNATURE OF DECEASED (If living)		17. SIGNATURE OF DECEASED (If living)		18. SIGNATURE OF DECEASED (If living)	
19. SIGNATURE OF DECEASED (If living)		20. SIGNATURE OF DECEASED (If living)		21. SIGNATURE OF DECEASED (If living)	
22. SIGNATURE OF DECEASED (If living)		23. SIGNATURE OF DECEASED (If living)		24. SIGNATURE OF DECEASED (If living)	
25. SIGNATURE OF DECEASED (If living)		26. SIGNATURE OF DECEASED (If living)		27. SIGNATURE OF DECEASED (If living)	
28. SIGNATURE OF DECEASED (If living)		29. SIGNATURE OF DECEASED (If living)		30. SIGNATURE OF DECEASED (If living)	
31. SIGNATURE OF DECEASED (If living)		32. SIGNATURE OF DECEASED (If living)		33. SIGNATURE OF DECEASED (If living)	
34. SIGNATURE OF DECEASED (If living)		35. SIGNATURE OF DECEASED (If living)		36. SIGNATURE OF DECEASED (If living)	
37. SIGNATURE OF DECEASED (If living)		38. SIGNATURE OF DECEASED (If living)		39. SIGNATURE OF DECEASED (If living)	
40. SIGNATURE OF DECEASED (If living)		41. SIGNATURE OF DECEASED (If living)		42. SIGNATURE OF DECEASED (If living)	
43. SIGNATURE OF DECEASED (If living)		44. SIGNATURE OF DECEASED (If living)		45. SIGNATURE OF DECEASED (If living)	
46. SIGNATURE OF DECEASED (If living)		47. SIGNATURE OF DECEASED (If living)		48. SIGNATURE OF DECEASED (If living)	
49. SIGNATURE OF DECEASED (If living)		50. SIGNATURE OF DECEASED (If living)		51. SIGNATURE OF DECEASED (If living)	
52. SIGNATURE OF DECEASED (If living)		53. SIGNATURE OF DECEASED (If living)		54. SIGNATURE OF DECEASED (If living)	
55. SIGNATURE OF DECEASED (If living)		56. SIGNATURE OF DECEASED (If living)		57. SIGNATURE OF DECEASED (If living)	
58. SIGNATURE OF DECEASED (If living)		59. SIGNATURE OF DECEASED (If living)		60. SIGNATURE OF DECEASED (If living)	
61. SIGNATURE OF DECEASED (If living)		62. SIGNATURE OF DECEASED (If living)		63. SIGNATURE OF DECEASED (If living)	
64. SIGNATURE OF DECEASED (If living)		65. SIGNATURE OF DECEASED (If living)		66. SIGNATURE OF DECEASED (If living)	
67. SIGNATURE OF DECEASED (If living)		68. SIGNATURE OF DECEASED (If living)		69. SIGNATURE OF DECEASED (If living)	
70. SIGNATURE OF DECEASED (If living)		71. SIGNATURE OF DECEASED (If living)		72. SIGNATURE OF DECEASED (If living)	
73. SIGNATURE OF DECEASED (If living)		74. SIGNATURE OF DECEASED (If living)		75. SIGNATURE OF DECEASED (If living)	
76. SIGNATURE OF DECEASED (If living)		77. SIGNATURE OF DECEASED (If living)		78. SIGNATURE OF DECEASED (If living)	
79. SIGNATURE OF DECEASED (If living)		80. SIGNATURE OF DECEASED (If living)		81. SIGNATURE OF DECEASED (If living)	
82. SIGNATURE OF DECEASED (If living)		83. SIGNATURE OF DECEASED (If living)		84. SIGNATURE OF DECEASED (If living)	
85. SIGNATURE OF DECEASED (If living)		86. SIGNATURE OF DECEASED (If living)		87. SIGNATURE OF DECEASED (If living)	
88. SIGNATURE OF DECEASED (If living)		89. SIGNATURE OF DECEASED (If living)		90. SIGNATURE OF DECEASED (If living)	
91. SIGNATURE OF DECEASED (If living)		92. SIGNATURE OF DECEASED (If living)		93. SIGNATURE OF DECEASED (If living)	
94. SIGNATURE OF DECEASED (If living)		95. SIGNATURE OF DECEASED (If living)		96. SIGNATURE OF DECEASED (If living)	
97. SIGNATURE OF DECEASED (If living)		98. SIGNATURE OF DECEASED (If living)		99. SIGNATURE OF DECEASED (If living)	
100. SIGNATURE OF DECEASED (If living)		101. SIGNATURE OF DECEASED (If living)		102. SIGNATURE OF DECEASED (If living)	

RECEIVED
MAY 11 1941

121
100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5514 CERTIFICATE OF DEATH

Reg. Dist. No.

05520

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 1 Month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 208 Park Circle		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNA First MAY Middle MENGES Last				4. DATE OF DEATH May 30 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 15, 1898		9. AGE (In years lost birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail		10b. KIND OF BUSINESS OR INDUSTRY Sales		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William R. Heavellow				14. MOTHER'S MAIDEN NAME Daisey Money			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 222-01-8083		17. INFORMANT William R. Edmanson Address Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Clear cell carcinoma of renal origin 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH about 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 28, 19 59 to May 30, 1959, that I last saw the deceased alive on May 30, 1959, and that death occurred at 3:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews, Jr., M.D.				ADDRESS (Street, city or town, state) 233 E. Main St.		DATE SIGNED May 30, 1959	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.				Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/2/1959		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Chesapeake City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME 200 N. 2nd Elkton, Md.				24a. REC'D BY REGISTRAR DATE JUN 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5535 · CERTIFICATE OF DEATH

Reg. Dist. No.

05521
96

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN lb 51 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, d. STREET ADDRESS 3607 Longfellow St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BERT P. MEYEN				4. DATE OF DEATH Month Day Year May 9 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1894	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Omaha, Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul Meyen				14. MOTHER'S MAIDEN NAME Pauline Schwag			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. Unknown		INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia, left lung 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma right lung, removal 4-17-59						INTERVAL BETWEEN ONSET AND DEATH 3 days Unk.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hyattsville,	(County) Prince George's	(State) Md.	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from March 19, 1959, to May 9, 1959 , and that death occurred at 2:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5-10-59 DATE SIGNED ACTUAL SIGNATURE J. L. GAREY M.D. V. A. Hospital, Perry Point, Md. PHYSICIAN'S NAME (Type) Clinical Pathologist							
22a. FUNERAL, CREMATION, REMOVAL (Specify) 5/15/59	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) Ft. Myer, Virginia.	(State) Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE PENNINGTON & SONS, Havre de Grace, Md.			24a. REC'D BY REGISTRAR DATE MAY 20 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
CERTIFICATE OF DEATH

Decd. Name: _____

Sex: _____

Age: _____

Place of Birth: _____

Marital Status: _____

Occupation: _____

Signature of Decd.: _____

Signature of Physician: _____

Signature of Coroner: _____

Signature of Registrar: _____

Signature of Burial Officer: _____

Signature of Minister: _____

Signature of Undertaker: _____

Signature of Witness: _____

Signature of Minister: _____

Signature of Undertaker: _____

Signature of Witness: _____

Signature of Minister: _____

Signature of Undertaker: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5515 CERTIFICATE OF DEATH

05522

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DELAWARE</u> b. COUNTY <u>NEW CASTLE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EIKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>		d. STREET ADDRESS <u>18 AUGUSTA Rd</u> <u>Chestnut Hill</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>-</u> Last <u>Powell</u>		4. DATE OF DEATH Month <u>5-</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-25-1881</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MILWORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FIBRE</u>	
11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>- Powell</u>		14. MOTHER'S MAIDEN NAME <u>MARY Voshell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>222-07-8207</u>	
17. INFORMANT <u>Richard Cikus</u> Address <u>18 Augusta Rd Newark Dela</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Vascular Disease</u> DUE TO (c) <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-21</u> , 19 <u>59</u> , to <u>5-21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-21</u> , 19 <u>59</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Williford Eppes</u> M.D.		ADDRESS (Street, city or town, state) <u>325 E Main Street</u> <u>Newark, Delaware</u>	
PHYSICIAN'S NAME (Type) <u>Williford Eppes</u>		DATE SIGNED <u>5-21-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-24-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NEWARK Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>NEWARK</u> <u>Dela.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Newark</u>		ADDRESS <u>NEWARK Dela</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

CERTIFICATE OF DEATH

Page One of One

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]		DATE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		MEDICAL HISTORY [Illegible]		PRESENT ILLNESS [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF DEATH REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]	
NAME OF PHYSICIAN [Illegible]		NAME OF DEATH REGISTRAR [Illegible]		NAME OF WITNESS [Illegible]	
ADDRESS OF PHYSICIAN [Illegible]		ADDRESS OF DEATH REGISTRAR [Illegible]		ADDRESS OF WITNESS [Illegible]	
CITY OF PHYSICIAN [Illegible]		CITY OF DEATH REGISTRAR [Illegible]		CITY OF WITNESS [Illegible]	
STATE OF PHYSICIAN [Illegible]		STATE OF DEATH REGISTRAR [Illegible]		STATE OF WITNESS [Illegible]	
COUNTY OF PHYSICIAN [Illegible]		COUNTY OF DEATH REGISTRAR [Illegible]		COUNTY OF WITNESS [Illegible]	
ZIP CODE OF PHYSICIAN [Illegible]		ZIP CODE OF DEATH REGISTRAR [Illegible]		ZIP CODE OF WITNESS [Illegible]	



This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his or her illness or injury. It should be filled out as soon as possible after death, and should be filed with the local health department or the state health department. The information on this certificate is used for statistical purposes only and is not to be used for legal purposes.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5516 CERTIFICATE OF DEATH

Reg. Dist. No.

05523

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
c. LENGTH OF STAY IN 1b 9 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Howard Rodney Purner		4. DATE OF DEATH Month Day Year May 11 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1957
9. AGE (In years lost birthday) --- yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Rodney Purner		14. MOTHER'S MAIDEN NAME Rachel Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father		Address Chesapeake City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis + Pneumonia 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity			INTERVAL BETWEEN ONSET AND DEATH 3 days
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 2, 1957, to May 11, 1959, that I last saw the deceased alive on 11 May, 1959, and that death occurred at 8:03 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Wallace Obenshain M.D.		ADDRESS (Street, city or town, state) Cecilton, Md.	
DATE SIGNED 11 May 59			
PHYSICIAN'S NAME (Type) Wallace Obenshain			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/13/1959	22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	22d. LOCATION (City, town, or county) (State) Nr. Chesapeake City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME Donald M. Pippin Elkton, Md.		24a. REC'D BY REGISTRAR DATE MAY 14 59	24b. REGISTRAR'S SIGNATURE Arthur L. Phipps

2065262XV2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1
5517 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05524

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Minnie Rattenbury</u>		4. DATE OF DEATH Month <u>5</u> Day <u>17</u> Year <u>19 59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-3-1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired T. Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Rattenbury</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Ewing</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Union Hospital Records, Elkton, Md.</u>	
17. INFORMANT <u>Union Hospital Records, Elkton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured of neck left femur</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypostatic Pneumonia</u> (c) <u>9040</u> DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in her home</u>	
20c. TIME OF INJURY Month, Day, Year <u>11 59 59</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Elkton, R.D. 3 Cecil Md.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. C. Dodson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5-17-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5-20-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MARY ANN EPISCOPAL</u>	22d. LOCATION (City, town, or county) <u>NORTH EAST</u> (State) <u>Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph B Grant</u>		ADDRESS <u>North East, Md</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Howard</u>	

85234

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1917

PLACE OF DEATH		Municipality		County	
Home		Baltimore		Baltimore	
Date of Death		Time of Death		Day of Week	
April 10, 1917		10:30 AM		Monday	
Age		Sex		Race	
35		Male		White	
Marital Status		Occupation		Education	
Single		Physician		High School	
Cause of Death		Immediate Cause		Underlying Cause	
Hypertension		Hypertension		Hypertension	
Place of Burial		Name of Burial Place		City and State	
Home		Union Medical Records, Baltimore, Md.		Baltimore, Md.	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]	
Date		Time		Day of Week	
April 10, 1917		10:30 AM		Monday	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5518

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05525

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elk Mills		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last George Franklin Rutter				4. DATE OF DEATH Month Day Year 5 22 19 59			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-31-1901	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Parts		10b. KIND OF BUSINESS OR INDUSTRY Chrysler Corp?		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Rutter				14. MOTHER'S MARDEN NAME Elizabeth Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 211-07- 7244		17. INFORMANT Address Mrs. Anna M Rutter, Elk Mills, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. D. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) R. D. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-25-59		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cem.		22d. LOCATION (City, town, or county) (State) Cherry Hill Cecil Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME				ADDRESS ELKTON MD		24a. REC'D BY REGISTRAR DATE MAY 26 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5519 CERTIFICATE OF DEATH

Reg. Dist. No. 05526

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 70 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 416 North Street				d. STREET ADDRESS 416 North Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LEWIS A. Seth				4. DATE OF DEATH Month 5 Day 17 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 13, 1882		9. AGE (In years lost birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realtor		10b. KIND OF BUSINESS OR INDUSTRY Sales		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Seth				14. MOTHER'S MAIDEN NAME Lena Carr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-12-6789		17. INFORMANT W. Andrew Seth Address Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x UREMIA of Cerebral Fracture DUE TO -C.V.A. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Diabetes Mellitus & Arteriosclerosis (c)							INTERVAL BETWEEN ONSET AND DEATH 48 hrs 2 mo 2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 29 March, 1959, to 17 May, 1959, that I last saw the deceased alive on 5/17/59, 19, and that death occurred at 2:40 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George J. Kries M.D.				ADDRESS (Street, city or town, state) Elkton, Md. DATE SIGNED 5/19/59			
PHYSICIAN'S NAME (Type) George J. Kries							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 21, 1959		22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Park		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME Donald M. Pippin Elkton, Md.				24a. REC'D BY REGISTRAR DATE MAY 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

15328

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH AND DEATH

CERTIFICATE OF DEATH

Reg. No. 15328

1. NAME OF DECEASED John A. Smith		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 10-15-1880		5. PLACE OF BIRTH Worcester, Mass.	
6. OCCUPATION Engineer		7. MARITAL STATUS Married		8. DATE OF DEATH 10-25-1925		9. PLACE OF DEATH Worcester, Mass.		10. CAUSE OF DEATH Heart Disease	
11. SIGNATURE OF DECEASED John A. Smith		12. SIGNATURE OF NEXT OF KIN John A. Smith		13. SIGNATURE OF PHYSICIAN John A. Smith		14. SIGNATURE OF REGISTRAR John A. Smith		15. SIGNATURE OF CLERK John A. Smith	
16. DATE OF REGISTRATION 10-25-1925		17. PLACE OF REGISTRATION Worcester, Mass.		18. NAME OF REGISTRAR John A. Smith		19. NAME OF CLERK John A. Smith		20. NAME OF PHYSICIAN John A. Smith	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05527

5520

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>all life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 Elkton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>182 Hollingsworth Manor</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Milford</u> <u>Ayres</u> <u>Simmons</u>				4. DATE OF DEATH Month <u>5</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>2-2-1907</u>		9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar Tender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Saloon</u>		11. BIRTHPLACE (State or foreign country) <u>Elkton, Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Wesley Simmons</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Sick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>W.W.2</u>		16. SOCIAL SECURITY NO. <u>216-01-4590</u>		17. INFORMANT <u>Mrs. Milford A. Simmons, Elkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Perforating bullet 25 caliber wound in right temple</u> DUE TO (b) <u>and made exit left side of head.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with 25 caliber automatic revolver in the right temple</u>					
20c. TIME OF INJURY Month, Day, Year <u>10.25</u> <u>5</u> <u>17</u> <u>59</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Elkton</u>		(County) <u>Cecil</u>		(State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.C. Dodson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5-17-59</u>			
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/20/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ELKTON CEMETERY</u>			
22d. LOCATION (City, town, or county) <u>ELKTON, Md.</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u>		ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR <u> </u>			
24b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u>MAY 21 '59</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5536

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 2mos.6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROLAND Middle A. Last TYSON		4. DATE OF DEATH Month May Day 29, Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-2-90
9. AGE (In years last birthday) yrs. 68		10. IF UNDER 1 YEAR Months 6 Days 29 Hours 19 Min. 59	11. IF UNDER 24 HRS. Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES TYSON		14. MOTHER'S MAIDEN NAME ELIZABETH HUMPHREY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address Hospital Records, VAH., Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia acute & chronic with pulmonary edema Several weeks DUE TO (b) Arteriosclerotic heart disease with marked coronary sclerosis unknown DUE TO (c) Primary carcinoma of lung unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary fibrosis & emphysema			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 23, 19 59 , to May 29, 19 59 , and that death occurred at 3:25A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 5-29-59			
ACTUAL SIGNATURE B. S. LINN		PHYSICIAN'S NAME (Type) B. S. LINN	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 6/3/59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE PENNINGTON & SON, Havre DeGrace, Md.		24a. REC'D BY REGISTRAR DATE JUN 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

03228

CERTIFICATE OF DEATH

First Name

Last Name

Birth

Place of Birth

Time of Death

Place of Death

Age at Death

Cause of Death

Sex

Color

Date of Death

Time of Death

USA

State

County

City

Signature of Registrar

Signature of Physician

Witnesses

Signature of Coroner

Signature of Registrar

Signature of Physician

Signature of Coroner

Signature of Registrar

Signature of Physician

Signature of Coroner

Signature of Registrar

Signature of Physician

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05529

Reg. Disf. No. 96

5537

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		c. LENGTH OF STAY IN 1b <u>2 mo. 10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burlington</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>122 E. Pearl Street</u>			
3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>(NMI)</u> Last <u>VANLEER</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>		9. AGE (In years last birthday) <u>65?</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter Vanleer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Hospital Records, VAH, Perry Point, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia unresolved</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral hemorrhage right side, subdural</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down cellar steps.</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u>XXXXX</u> <u>2-19, 59</u> P. M.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Burlington, New Jersey</u>		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. C. DODSON</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R. C. DODSON</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>5/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beverly National</u>		22d. LOCATION (City, town, or county) <u>Beverly, New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pennington & Son, Havre de Grace, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - COLUMBIA, MO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2237

22

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of death: <u>Jan 1, 1950</u></p>	
<p>5. Place of death: <u>Home</u></p>		<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Manner of death: <u>Natural</u></p>		<p>8. Signature of Medical Examiner: <u>[Signature]</u></p>	
<p>9. Signature of Coroner: <u>[Signature]</u></p>		<p>10. Date of filing: <u>Jan 1, 1950</u></p>	
<p>11. Name of physician: <u>Dr. Smith</u></p>		<p>12. Name of hospital: <u>St. Mary's</u></p>	
<p>13. Name of funeral home: <u>ABC</u></p>		<p>14. Name of cemetery: <u>Greenwood</u></p>	
<p>15. Name of next of kin: <u>John Doe</u></p>		<p>16. Name of informant: <u>John Doe</u></p>	
<p>17. Name of witness: <u>John Doe</u></p>		<p>18. Name of witness: <u>John Doe</u></p>	
<p>19. Name of witness: <u>John Doe</u></p>		<p>20. Name of witness: <u>John Doe</u></p>	
<p>21. Name of witness: <u>John Doe</u></p>		<p>22. Name of witness: <u>John Doe</u></p>	
<p>23. Name of witness: <u>John Doe</u></p>		<p>24. Name of witness: <u>John Doe</u></p>	
<p>25. Name of witness: <u>John Doe</u></p>		<p>26. Name of witness: <u>John Doe</u></p>	
<p>27. Name of witness: <u>John Doe</u></p>		<p>28. Name of witness: <u>John Doe</u></p>	
<p>29. Name of witness: <u>John Doe</u></p>		<p>30. Name of witness: <u>John Doe</u></p>	
<p>31. Name of witness: <u>John Doe</u></p>		<p>32. Name of witness: <u>John Doe</u></p>	
<p>33. Name of witness: <u>John Doe</u></p>		<p>34. Name of witness: <u>John Doe</u></p>	
<p>35. Name of witness: <u>John Doe</u></p>		<p>36. Name of witness: <u>John Doe</u></p>	
<p>37. Name of witness: <u>John Doe</u></p>		<p>38. Name of witness: <u>John Doe</u></p>	
<p>39. Name of witness: <u>John Doe</u></p>		<p>40. Name of witness: <u>John Doe</u></p>	
<p>41. Name of witness: <u>John Doe</u></p>		<p>42. Name of witness: <u>John Doe</u></p>	
<p>43. Name of witness: <u>John Doe</u></p>		<p>44. Name of witness: <u>John Doe</u></p>	
<p>45. Name of witness: <u>John Doe</u></p>		<p>46. Name of witness: <u>John Doe</u></p>	
<p>47. Name of witness: <u>John Doe</u></p>		<p>48. Name of witness: <u>John Doe</u></p>	
<p>49. Name of witness: <u>John Doe</u></p>		<p>50. Name of witness: <u>John Doe</u></p>	
<p>51. Name of witness: <u>John Doe</u></p>		<p>52. Name of witness: <u>John Doe</u></p>	
<p>53. Name of witness: <u>John Doe</u></p>		<p>54. Name of witness: <u>John Doe</u></p>	
<p>55. Name of witness: <u>John Doe</u></p>		<p>56. Name of witness: <u>John Doe</u></p>	
<p>57. Name of witness: <u>John Doe</u></p>		<p>58. Name of witness: <u>John Doe</u></p>	
<p>59. Name of witness: <u>John Doe</u></p>		<p>60. Name of witness: <u>John Doe</u></p>	
<p>61. Name of witness: <u>John Doe</u></p>		<p>62. Name of witness: <u>John Doe</u></p>	
<p>63. Name of witness: <u>John Doe</u></p>		<p>64. Name of witness: <u>John Doe</u></p>	
<p>65. Name of witness: <u>John Doe</u></p>		<p>66. Name of witness: <u>John Doe</u></p>	
<p>67. Name of witness: <u>John Doe</u></p>		<p>68. Name of witness: <u>John Doe</u></p>	
<p>69. Name of witness: <u>John Doe</u></p>		<p>70. Name of witness: <u>John Doe</u></p>	
<p>71. Name of witness: <u>John Doe</u></p>		<p>72. Name of witness: <u>John Doe</u></p>	
<p>73. Name of witness: <u>John Doe</u></p>		<p>74. Name of witness: <u>John Doe</u></p>	
<p>75. Name of witness: <u>John Doe</u></p>		<p>76. Name of witness: <u>John Doe</u></p>	
<p>77. Name of witness: <u>John Doe</u></p>		<p>78. Name of witness: <u>John Doe</u></p>	
<p>79. Name of witness: <u>John Doe</u></p>		<p>80. Name of witness: <u>John Doe</u></p>	
<p>81. Name of witness: <u>John Doe</u></p>		<p>82. Name of witness: <u>John Doe</u></p>	
<p>83. Name of witness: <u>John Doe</u></p>		<p>84. Name of witness: <u>John Doe</u></p>	
<p>85. Name of witness: <u>John Doe</u></p>		<p>86. Name of witness: <u>John Doe</u></p>	
<p>87. Name of witness: <u>John Doe</u></p>		<p>88. Name of witness: <u>John Doe</u></p>	
<p>89. Name of witness: <u>John Doe</u></p>		<p>90. Name of witness: <u>John Doe</u></p>	
<p>91. Name of witness: <u>John Doe</u></p>		<p>92. Name of witness: <u>John Doe</u></p>	
<p>93. Name of witness: <u>John Doe</u></p>		<p>94. Name of witness: <u>John Doe</u></p>	
<p>95. Name of witness: <u>John Doe</u></p>		<p>96. Name of witness: <u>John Doe</u></p>	
<p>97. Name of witness: <u>John Doe</u></p>		<p>98. Name of witness: <u>John Doe</u></p>	
<p>99. Name of witness: <u>John Doe</u></p>		<p>100. Name of witness: <u>John Doe</u></p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

5521

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05530

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Del. b. COUNTY New Castle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delaire 46 X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS 107 Sunset Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last James L Vaughan		4. DATE OF DEATH Month 5 Day 23 Year 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Efficiency Ret.		10b. KIND OF BUSINESS OR INDUSTRY Dupont Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James H. Vaughan		14. MOTHER'S MAIDEN NAME Sarah Layman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. 146-09-6754	
17. INFORMANT James L. Vaughan, Jr.		Address Del. 107 Sunst Drive, De	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Massive Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . ACTUAL SIGNATURE R.C. Dodson M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) R.C. Dodson ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 5-23-59 22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 5-27-59 22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery, nr. Chesapeake City, Md. 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joseph R. Grant, North East Pk. 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

05520

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased JAMES E. WILSON		2. Sex Male		3. Age 41	
4. Date of Death 10-1-1982		5. Time of Death 10:00 AM		6. Place of Death Home	
7. Usual Residence 1015 E. 10th St. Baltimore, Md. 21202		8. Cause of Death Myocardial Infarction		9. Manner of Death Natural	
10. Physician's Name Dr. J. H. Smith		11. Hospital Name None		12. Burial Place None	
13. Signature of Medical Examiner [Signature]		14. Signature of Coroner [Signature]		15. Date of Report 10-1-1982	

5538
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East				c. LENGTH OF STAY IN 1b 10 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Stanley Middle Nartin Last Williams Sr.				4. DATE OF DEATH Month May Day 15 Year 19 59			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 25, 1908	9. AGE (In years lost birthday) yrs. 50	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY DuPont Chestnut		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jesse C. Williams				14. MOTHER'S MAIDEN NAME Addie England			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mabel Barr Williams North East, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 3 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 12, 1959 , to May 14, 1959 , that I last saw the deceased alive on May 14, 1959 , and that death occurred at 12:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Clarence T. Benson M.D.				ADDRESS (Street, city or town, state) Port Deposit, Maryland			
PHYSICIAN'S NAME (Type) CLARENCE T. BENSON				DATE SIGNED May 15, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 18, 1959		22c. NAME OF CEMETERY OR CREMATORY Hopewell		22d. LOCATION (City, town, or county) (State) Port Deposit Rd Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant ADDRESS Joseph R. Grant North East, Maryland				24a. REC'D BY REGISTRAR DATE MAY 20 '59		24b. REGISTRAR'S SIGNATURE C. L. S. Knaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

